SPECTERA
A UnitedHealth Group Company

VISION BENEFIT COMMUNICATION

Program Year Effective 07/01/08

Underwritten by United HealthCare Insurance Company

BENEFITS AT A SPECTERA NETWORK PROVIDER	
COMPREHENSIVE VISION EXAM ($15 copay; Once Every 12 Months)	A vision examination is provided by a network optometrist or ophthalmologist, after applicable copay.
MATERIALS ($30 copay)	The materials copay is a single payment that applies to the entire purchase of eyeglasses (lenses and frames), or contacts in lieu of eyeglasses.
PAIR OF LENSES (for eyeglasses) (Once Every 12 Months) • Standard single vision • Standard lined bifocal • Standard lined trifocal • Standard lenticular	Standard scratch-resistant coating, tints, UV and progressive lenses are covered-in-full. Lens Options - Options such as polycarbonate lenses and anti-reflective coating may be available at a discount.
FRAMES (Once Every 24 Months)	Spectera's frame benefit applies to virtually all of the frames on the market today, and most of those are covered-in-full, without any additional cost to the member, other than applicable copay. Receive a $50 wholesale frame allowance (approximate retail value of $120 to $150) at private practice providers, or a minimum $130 frame allowance at retail chain providers.
Contact Lenses (in lieu of eyeglasses) (Once Every 12 Months) • Covered-in-full elective contact lenses • All other elective contacts • Necessary contact lenses*	The fitting/evaluation fees, contacts (including disposables), and up to two follow-up visits are covered-in-full (after applicable copay) for tthe most popular brands on the market. If covered disposable contact lenses are chosen, up to 4 boxes (depending on prescription) are included when obtained from a network provider. It is important to note that Spectera's covered-in-full contact lenses may vary by provider. A $105 allowance is applied toward the fitting/evaluation fees and purchase of contact lenses outside of Spectera's covered-in-full contacts (materials copay does not apply). Toric, gas permeable, and bifocal contacts are all examples of contacts that are outside of our covered-in-full selection. Covered-in-full (after applicable copay).
REFRACTIVE EYE SURGERY	Spectera participants receive access to discounted refractive eye surgery from numerous provider locations throughout the United States. To find a participating laser eye surgeon in your area, visit our Web site at www.spectera.com.
* Necessary contact lenses are determined at the provider's discretion for one or more of the following conditions: Following post cataract surgery without intraocular lens implant; To correct extreme vision problems that cannot be corrected with spectacle lenses; With certain conditions of anisometropia; With certain conditions of keratoconus. If your provider considers your contacts necessary, you should ask your provider to contact Spectera concerning the reimbursement that Spectera will make before you purchase such contacts.	

Spectera's vision benefit is very affordable.

Exam copay	$15
Materials copay	$30

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BENEFITS AT AN OUT-OF-NETWORK PROVIDER

SERVICE	AMOUNT	
Exam		
Optometrist	Up to	$40
Opthalmologist	Up to	$40
Lenses		
Single Vision	Up to	$40
Bifocal	Up to	$60
Trifocal	Up to	$80
Lenticular	Up to	$80
Frames	Up to	$45
Contact Lenses (in lieu of eyeglasses)		
Elective	Up to	$105
Necessary*	Up to	$210

If you choose an out-of-network provider, you will need to send your itemized receipts, with the primary-insured's unique identification number and the patient's name and date of birth, to:

Spectera Claims Department
P. O. Box 30978
Salt Lake City, UT 84130

Please note: Receipts for services and materials purchased on different dates must be submitted together at the same time to receive reimbursement.

Important to Remember:

- Always identify yourself as a Spectera participant when making your appointment. This will assist your provider in obtaining a claim authorization number prior to your visit.
- Benefits available every 12 or 24 months (depending on the benefit frequency), based on last date of service.
- Your $105 contact lens allowance is applied to the fitting/evaluation fees as well as the purchase of contact lenses. For example, if the fitting/evaluation fee is $30, you will have $75 towards the purchase of contact lenses. The allowance may be separated at some retail chain locations between the examining physician and the optical store. Toric, gas permeable, and bifocal contacts are all examples of contacts that are outside of our covered-in-full selection.

The following Services and Materials are excluded from coverage under the Policy:

1. Post cataract lenses
2. Non-prescription items
3. Medical or surgical treatment for eye disease, that requires the services of a physician
4. Worker's Compensation services or materials
5. Services or materials that the patient, without cost, obtains from any governmental organization or
6. Services or materials that are not specifically covered by the Policy
7. Replacement or repair of lenses and/or frames that have been lost or broken
8. Cosmetic extras, except as stated in the Policy's Table of Benefits

Please note: If there are differences in this document and the Group Policy, the Group Policy is the governing document.

Please retain this Benefit Summary and Vision Care Program description that includes detailed benefit information and instructions on how to use the program. Customer Service is available toll-free at 1-800-638-3120 from 8:00 a.m. to 11:00 p.m., Monday thru Friday, and from 9:00 a.m. to 5:30 p.m. on Saturdays.